Hemoglobin $P_{50}$ Dynamics During Hypothermic Cardiopulmonary Bypass

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Abstract

The hemoglobin $P_{50}$ was ascertained prior to anesthesia and CPB and calculated during hypothermic CPB to track the change in hemoglobin affinity in fifty randomly selected cardiac disease patients.

The AMINCO Hem-O-Scan standardized $P_{50}$ averaged 32.1 ± 6.8 (1 SD) mmHg in the awake, slightly sedated CPB candidate. The awake patients were distributed into three significantly different ($p < .05$) groups: left-shifted oxyhemoglobin dissociation curve (ODC), $P_{50} = 23.1$ ± 1.4, $n = 5$; normal ODC, $P_{50} = 27.2$ ± 1.3, $n = 13$; and right-shifted ODC, $P_{50} = 35.4$ ± 6.1, $n = 32$. The three groups converged at the termination of hypothermic CPB to a single group calculated, mean $P_{50} = 30.7$ ± 4.7 mmHg.

Unlike the previous studies of Woodson (1970) and Wilkinson (1979), the Hem-O-Scan pre-CPB $P_{50}$ demonstrated a weak inverse correlation to ejection fraction, cardiac index and hemoglobin flow index in this patient group. The position of the ODC prior to and during CPB may not be accurately predicted. Therefore, direct measurement of $pO_2$ and $O_2$ saturation of hemoglobin is recommended and calculator prediction of hemoglobin $O_2$ saturation from $pO_2$ assuming a beginning $P_{50} = 27$ mmHg may not be trusted in cardiac diseased patients.

Introduction

Evaluation of tissue oxygenation during extracorporeal circulation has been through intermittent blood gas analysis. With the recent availability of continuous monitors of oxygen saturation of hemoglobin ($O_2$ SAT) and partial pressure of oxygen ($pO_2$), questions of accuracy, monitoring necessity and cost effectiveness have arisen. If $pO_2$ or $O_2$ SAT could be employed to predict the other, the problem would be simplified.

The single indicator that states the relationship between $pO_2$ and $O_2$ SAT is the hemoglobin $P_{50}$; the $pO_2$ at which an individual’s hemoglobin is fifty percent saturated with oxygen.

The purpose of this study was to evaluate the predictability of the hemoglobin $P_{50}$ and track the $P_{50}$ change during hypothermic cardiopulmonary
bypass in a random sampling of fifty cardiac disease patients undergoing open heart surgery.

Severinghaus and others report the normal adult hemoglobin $P_{50}$ to be 27–28 mmHg with a standard deviation in the population equal to 1–2 mmHg.\textsuperscript{1,6}

Woodson, Kostuk, Agostoni, Shappell, Metcalfe, and others have correlated hemoglobin $P_{50}$ inversely with cardiac index, hemoglobin concentration, hemoglobin flow index, arteriovenous oxygen content difference, and red blood cell 2, 3 DPG in their cardiac disease populations.\textsuperscript{1-9}

Patients in cardiogenic shock with severe acidosis have dramatically right-shifted oxyhemoglobin dissociation curves to enhance oxygen delivery to tissue during shock.\textsuperscript{4}

Woodson and Valeri have documented the role of elevated red cell 2, 3 DPG in decreasing hemoglobin oxygen affinity and improving tissue oxygenation during compromised cardiac function.\textsuperscript{2,3} Valeri proposed that the hemoglobin $P_{50}$ is "a functional biopsy of the status of tissue oxygenation."\textsuperscript{3}

It may be concluded that if hemoglobin $P_{50}$ is known, then $O_2$ SAT may be predicted from $pO_2$ or the converse. Furthermore, the accurate prediction of an individual's $P_{50}$ from his or her medical data base would allow the justification of the continuous monitoring of only $pO_2$ or $O_2$ SAT with accurate prediction of the other. However, these assumptions are unlikely in that investigators have demonstrated alteration in the hemoglobin $P_{50}$ within an organ system (e.g. coronary sinus) compared to the individual's mixed venous hemoglobin $P_{50}$.\textsuperscript{6}

In the resuscitation of severely impaired, low cardiac output patients with cardiopulmonary bypass, one might expect hemoglobin $P_{50}$ to return to normal when the biochemical imbalances accompanying cardiogenic shock are corrected. Perhaps hemoglobin $P_{50}$ change during cardiopulmonary bypass may be employed to monitor the adequacy of ECC tissue oxygenation.

Hemoglobin $P_{50}$ dynamics prior to and during moderate hypothermic cardiopulmonary bypass were studied employing the following method.

### Methods

Fifty adult open heart patients undergoing various cardiac surgical procedures were randomly selected, and their medical records were reviewed to evaluate history, biochemistry, hematology, and cardiac function. Pre-operative ejection fraction, cardiac index (L/minute/M$^2$) and hemoglobin flow index (Gm%/L x minute/M$^2$) were collected to correlate to hemoglobin $P_{50}$.

A radial artery blood sample was drawn from each lightly sedated, awake CPB candidate breathing room air. The sample was analyzed for pH, $pO_2$, $pCO_2$ and base excess via the Corning 175.\textsuperscript{5} The sample was also analyzed for %Hb $\cdot$ CO and % Methemoglobin (% Met Hb) by the IL282 Co-oximeter\textsuperscript{b} and the oxyhemoglobin dissociation curve constructed with the Hem-0-Scan\textsuperscript{c} employing the manufacturer's instructions. The Hem-O-Scan 100% relative saturation ($O_2$ SAT Max) was adjusted for the %Hb $\cdot$ CO and % Met Hb with the following equations:

\[
F = \frac{\%HbCO + \%Met Hb}{SAT Max}
\]

\[
\text{ADJUSTED } O_2 \text{ SAT MAX } = \text{INITIAL } O_2 \text{ SAT MAX } + F
\]

The resulting $P_{50}$ was reported as the IN VIVO $P_{50}$.

The IN VIVO $P_{50}$ was standardized (STD $P_{50}$) to pH equal to 7.4, $pCO_2$ equal to 40 mmHg, and temperature equal to 37°C by the following equation.\textsuperscript{1}

\[
\text{STD } P_{50} = \text{IN VIVO } P_{50} e^{-0.5 F}
\]

\[F = \frac{\%HbCO + \%Met Hb}{SAT Max}
\]

\[
\text{ADJUSTED } O_2 \text{ SAT MAX } = \text{INITIAL } O_2 \text{ SAT MAX } + F
\]

\[
\text{STD } P_{50} = \text{IN VIVO } P_{50} e^{-0.5 F}
\]

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\]

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\]
P50 Distribution

awake, pre CPB
pH=7.39, pCO₂=39, °C=36.7
n=50

STD P50 = Hem-O-Scan P50 + .0755
× (40-pCO₂) + 26.66 × (pH-7.4)
+ 1.25 × (37-°C)

Anesthesia was obtained with 50-100 ug/kg fentanyl citrate or 1-2 mg/kg morphine sulfate. Muscle relaxation was established with about .15 mg/kg pancuronium hydrochloride. Bypass was initiated with a cardiac index of 2.2 to 2.7 L/min/ M² and 28°C hypothermia was instituted. The perfusionist attempted to maintain the temperature corrected pH and blood gases within 37°C normal ranges. Donor blood was employed to maintain the hematocrit above 22%.

Venous hemoglobin O₂ SAT was continuously monitored with the Oxy Sat Meter and maintained greater than 65% at 37°C and greater than 87% at 28°C. Base deficit was not corrected during hypothermia.

Blood gas analyses were obtained every 15-20 minutes during CPB and just prior to termination. The P50 during bypass was estimated employing Severinghaus' method.

Results

Figures 1 and 2 display the distribution of the IN VIVO P50 (32.9 ± 7.2 mmHg) and the STD P50 (32.1 ± 6.8 mmHg) pre-anesthesia. The STD P50's were divided into three groups: Normal STD P50 = 25 to 29 mmHg; high STD P50 greater than 29 mmHg and low STD P50 less than 25 mmHg. Table 1 lists the group statistics. Confidence intervals were constructed for the unequal patient groups to test for significant differences at p < .05.

Figure three depicts the hypothermic ODC left shift with hypothermic CPB. The three groups converge during CPB warming to demonstrate no significant difference at termination of CPB. The STD P50 post CPB averaged 30.7 ± 4.7 mmHg.

Table 2 exhibits the weak predicting power of preoperative medical record physiologic parameters. In this group, ejection fraction averaged .63 ± .13 (1 SD) and was as low as .35 and as great

<table>
<thead>
<tr>
<th>HEMOGLOBIN P50 GROUP</th>
<th>PRIOR TO CPB</th>
<th>END OF CPB</th>
<th>SIGNIFICANCE BETWEEN ROWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Shifted (n = 32)</td>
<td>35.4 +/- 6.1</td>
<td>31.2 +/- 5.4</td>
<td>p &lt; .01</td>
</tr>
<tr>
<td>between groups:</td>
<td>p &lt; .01</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Normal (n = 13)</td>
<td>27.2 +/- 1.3</td>
<td>31.2 +/- 2.9</td>
<td>p &lt; .01</td>
</tr>
<tr>
<td>between groups:</td>
<td>p &lt; .05</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Left Shifted (n = 5)</td>
<td>23.1 +/- 1.4</td>
<td>27.8 +/- 4.2</td>
<td>p &lt; .05</td>
</tr>
</tbody>
</table>

Table 1

The mean +/- one standard deviation for each resulting study subgroup prior to CPB and at the termination of CPB. The significance between groups and rows was tested by constructing confidence limits for each cell.
as .87. Pre-CPB hemoglobin flow averaged 34.4 ± 16.5 (1 SD) and spanned the limits of 17.5 to 75.2 Gm%/L × min/M². Pre-operative CI was 2.45 ± .73 L/min/M² and varied from 1.33 to 4.95 in those 50 patients. Post-CPB CI was 2.66 ± .27 L/min/M².

Discussion

The individual cardiac disease patient’s oxyhemoglobin curve position may not be known or confidently predicted prior to CPB. However, in this study, 64% of patients arrived in the operating room suite with right-shifted ODC’s.

Patients with compromised cardiac function compensate to facilitate oxygen transfer by decreasing hemoglobin oxygen affinity.1-4,6-8 Elevated P₅₀ is common in patients in chronic CHF, cardiogenic shock, post MI, anemia, and cardiomyopathies.1-4 Change in red cell 2,3 DPG largely mediates change in hemoglobin P₅₀ in conjunction with acid base effects on the ODC.2-4

It is reasonable to hypothesize that an individual’s hemoglobin P₅₀ may be predicted by cardiac function parameters. However, only weak, inverse correlations were observed in this patient group between P₅₀ and ejection fraction, cardiac index, and hemoglobin flow index.

The initiation of increased cardiac index CPB and corrective measures (e.g. surgery, acid base imbalance correction) probably reverse the processes elevating P₅₀ and return the ODC toward a normal position. The minute relationship between decrease in P₅₀ pre to post CPB with change in cardiac index and the total group mean P₅₀ equal to 30.7 ± 4.7 mmHg at CPB termination support the role of increasing blood flow shifting the ODC to the left.

The position of the oxyhemoglobin dissociation curve can not be accurately predicted and changes dynamically prior to and during hypothermic CPB. Therefore, direct measurement of pO₂ and saturation is indicated during CPB. Calculator prediction of O₂ SAT from pO₂ assuming a beginning P₅₀ equal to 27 mmHg can not be trusted.

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References